

- ◇ Does the health plan require you to see providers in their network?
- ◇ Does the health plan pay for you to see a doctor or use a hospital outside the network?
- ◇ Are the network providers conveniently located?
- ◇ Is the doctor you want to see in the network accepting new patients?
- ◇ What do you have to do to see a specialist?
- ◇ How easy is it to get an appointment when you need one?

Questions About Customer Service

- ◇ Has the company had an unusually high number of consumer complaints?
- ◇ What happens when you call the company's consumer complaint number?
- ◇ How long does it take to reach a real person?

The information provided in this brochure is general and may not apply in all circumstances. The focus of this brochure is on health plans that provide coverage for major medical expenses, which include the cost of hospital bills and medical bills (both in and out of the hospital). For help with your specific concerns, you may want to talk with your employer's benefits department, an independent professional advisor, or contact MID's Consumer Services Division at 800-562-2957.

MISSISSIPPI
INSURANCE
DEPARTMENT

Internet: www.mid.state.ms.us
Mail: P.O. Box 79, Jackson, MS 39205-0079
Street: 501 N. West St., Suite 1001, Jackson, MS 39201

Phone: 601.359.3569
Intrastate Toll-Free: 800.562.2957
Fax: 601.359.1077

Health Insurance Shopper's Guide



Mike Chaney
Insurance Commissioner
State Fire Marshal

Revised January 2008

Health Insurance: What You May Expect

Purchasing health insurance is a very important decision. Many tend to base their entire insurance purchasing decision on the premium amount. As well as obtaining a good value, it is also vitally important that you deal with a company that is financially stable.



Mike Chaney

Types of Insurance

There are several different kinds of health insurance. Traditional insurance often is called a "fee for service" or "indemnity" plan. If you have traditional insurance, the insurer pays the bills after you receive the service. Managed care plans use your monthly payments to cover most of your medical expenses. Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are the most common managed care organizations.

Managed care plans provide health care in a more structured way than traditional insurance. Managed care plans encourage and in some cases require consumers to use doctors and hospitals that are part of a network. In both traditional insurance and managed care plans, consumers may share the cost of a service. This cost sharing is often called a co-payment, co-insurance or deductible.

Many different terms are used in discussing health insurance. "Covered persons" or "enrollees" are individuals who are enrolled in a health insurance plan. "Providers" are doctors, hospitals, pharmacies, labs, urgent care facilities and other health care facilities and professionals.

Disclosure Requirements

Whether you are considering enrolling in a traditional insurance plan or managed care plan, you should know your legal rights. Mississippi law requires all insurers to clearly and truthfully disclose the following information in their insurance policies:

- ◇ A complete list of items and services that the health care plan pays for.
- ◇ A complete list of items and services that the health care plan does not pay for (exclusions and limitations).
- ◇ Any situations where the plan may not pay for all of your medical care (exceptions, reductions and limitations).
- ◇ How long you may have to wait before the policy covers recent health problems (pre-existing condition exclusion period).
- ◇ How the policy may be renewed;
- ◇ How the policy may be canceled;
- ◇ How the policy may be terminated;

A health plan may refuse to pay for health care services that relate to a health condition you had before joining your health plan. This is called a "pre-existing condition exclusion period". State laws limit how long preexisting condition exclusion periods can be for individual and group health plans.

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- ◇ If you have a group health plan, a pre-existing condition is a health condition for which medical advice, diagnosis, care or treatment was recommended or received within 6 months of joining a plan. Your plan may refuse to pay for services related to your pre-existing condition for 12 months.
- ◇ If you have an individual plan, a pre-existing condition is a health condition for which medical advice, diagnosis, care or treatment was recommended or received within 12 months of joining your plan. Your plan may refuse to pay for services related to your pre-existing condition for 12 months.

You may not have to serve a pre-existing condition exclusion period if you are able to get credit for your health care coverage you had before you joined your new plan. This is called “creditable coverage” and generally applies to group insurance. Ask your plan for more information. Your health insurer must renew your plan if you want to renew it. The insurer cannot cancel your policy unless it pulls out of the Mississippi market entirely, or you commit fraud or abuse or you do not pay your premiums.

Complaint Procedures

All health care plans must have written procedures for receiving and resolving complaints. These are often called grievance procedures. Grievance procedures must be consistent with state law requirements.

If your health insurer has refused to pay for health care services that you have received or want to receive, you have the right to know the exact contractual, medical or other reason why.

If you have a complaint about a health insurer or an agent, you can send it in writing to the Mississippi Insurance Department at P.O. Box 79, Jackson, MS 39205. You can also download a complaint form using MID’s Internet site at www.mid.state.ms.us/howtofileacomplaint.html. MID keeps track of the complaints that are filed. However, remember that when you are comparing companies and asking for the number of complaints that have been filed against a company, you must be aware that generally the company with the most policies in force will have more complaints than companies that only have a few policies in place.

Managed Care Plans

Every managed care plan must have enough providers so that you can get the care you need without unreasonable delay.

Every managed care plan must file a description of its network of providers and how it makes sure the network can provide health care services without unreasonable delay.

Sometimes, a doctor, hospital, or other health care facility leaves a managed care plan’s network. When this happens, a managed care plan must notify you if you saw that provider on a regular basis.

As a covered person, you and your doctor have the right to a complete list of providers that are part of the managed care plan’s network. You must get this list when you enroll, re-enroll, or upon request.



Need help?
Contact MID at
800 562 2957

Every managed care plan must keep close track of the quality of the health care services it provides. Managed care plans should not use rewards or penalties that encourage less care than is medically necessary. If you want to know more about how your plan pays its providers, you should ask.

Your managed care plan should notify you if it refuses to pay for a health care service based on a decision that is not medically necessary, efficient, effective or appropriate. The notice should include the main reasons for the denial and instructions on how to appeal.

Every managed care plan should follow certain procedures if it determines that a health care service was not medically necessary, efficient, effective or appropriate. The procedures must be fully described in the certificate of coverage or member handbook.

Shopping for Health Insurance

When shopping for health insurance it is important to make sure that you are buying the health care plan you want and can afford. You should make a list of your needs to compare with the benefits offered by a plan you are considering. You should compare plans to find out why one is cheaper than another. Listed below are some questions you should ask when shopping for health insurance:

Questions About Coverage

- ◇ What does the plan pay for and not pay for?
- ◇ Will the plan pay for preventative care, immunizations, well-baby care, substance abuse, organ transplants, vision care, dental care, infertility treatment, or durable medical equipment?
- ◇ Will the plan pay for any prescriptions? If it pays for some, will it pay for all prescriptions?
- ◇ Does the plan have mental health benefits?
- ◇ Will the plan pay for long term physical therapy?

Not all plans cover all of the benefits listed above. Be sure to ask about benefits.

Questions About Premiums

- ◇ Do rates increase as you age?
- ◇ How often can rates be changed?
- ◇ How much do you have to pay when you receive health care services (co-payments and deductibles)?
- ◇ Are there any limits on how much you must pay for health care services you receive (out of pocket maximums)?
- ◇ Are there any limits on the number of times you may receive a service (lifetime maximums or annual benefit caps)?

Questions About Providers

- ◇ What are the restrictions on the use of providers or services under the plan?